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(5) The department, in order to ensure accuracy of the patient review form (PRI), may also conduct timely on-site observations and/or interviews of patients/residents and review of their medical records. When an additional on-site review is performed by the department as a result of controverted items found during the initial on-site review, the facility shall be afforded an on-site conference prior to the conclusion of such additional on-site review. Upon completion of a department on-site review pursuant to this subdivision, the department, in order to ensure accuracy of the patient review form (PRI), shall correct, where necessary, a residential health care facility's assessment of its patient case mix intensity. The department's on-site determination shall be considered final for purposes of assessing the residential health care facility's case mix intensity for that assessment period and notwithstanding section 2.14 of this Subpart, the residential health care facility may not correct or amend the patient form (PRI) or submit any additional information after department reviewers have concluded the on-site review. The residential health care facility shall be notified in writing regarding the department determination of any controverted items.

JUL. 29 1987

JAN. 1 1988

Approval Date
Effective Date

86-4
superseded
85-6

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(f) (1) If the department determines pursuant to this section, that a residential health care facility is not performing its case mix intensity assessment function in a timely and/or accurate manner, as required by subdivision (b) of this section, the department shall, in writing:

(i) Notify the residential health care facility;
and

(ii) Require the residential health care facility to perform its patient case-mix assessment function through written agreement with a person or entity approved by the department for the completion of the patient review form (PRI) for the purpose of establishing a residential health care facilities case mix reimbursement.

(iii) Any patient case mix assessment performed pursuant to subparagraph (ii) of the paragraph shall also be subject to department monitoring and review pursuant to this section.

(2) The department shall determine that a residential health care facility is not performing its case-mix intensity assessment function in an accurate manner where there exists inaccuracies in its case-mix assessment which results in a statistically significant modification of the residential health care facility's reimbursement.

JUL 29 1987

Approval Date

JAN 1 1986

Effective Date

86-4

supersedes

85-6

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(3) The cost of written agreements required by paragraph (1) of this subdivision shall not be considered an allowable cost for determining reimbursement rates pursuant to this Subpart.

(4) Certification. Operators of residential health care facilities completing the department's patient review form (PRI) through written agreement with a department approved non-residential health care facility person or entity shall have such form certified by such person or entity in lieu of a facility registered professional nurse as required by paragraph (2) of subdivision (c) of this section.

(g) Reconsiderations.

(1) Any residential health care facility after one year from the date it has been notified in writing by the department that it must enter into a written agreement pursuant to paragraph (1) of subdivision (f) of this section, may request, in writing, that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(2) The department shall not rescind its withdrawal of a residential health care facility's patient case mix assessment function unless the residential health care

JAN. 1 1986

Effective Date

JUL. 29 1987

Approval Date

86-4

superseded

85-6

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facility satisfies the department that the residential health care facility has the capability to comply with the requirements of the department's patient casemix assessment process which shall include the capability to accurately complete the patient review form (PRI).

(3) The department shall give written notice of its decision and shall, if negative, give a statement of the reasons for its refusal to rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(4) Any residential health care facility after six months from the date it receives a written department decision pursuant to paragraph (3) of this subdivision, may again request in writing that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

[(h) The provisions of this section shall expire on April 30, 1989.]

TN 89-24 Approval Date MAY 16 1986
Supersedes TN 88-4 Effective Date APR 19 1989

(j) Residential health care facilities [with 80 or more beds] shall submit the data contained in the PRI using an electronic medium including but not limited to magnetic computer tape, floppy disk or an electronic telecommunication system consistent with the technical specifications established by the department.

[(i)] (1) The electronically produced data shall be accompanied by a certification statement executed by the operator or a person authorized to sign on the operator's behalf in a format provided or approved by the department.

[(ii)] (2) Facilities [required or those electing to submit PRI data in this format] shall have an additional ten days from the time specified pursuant to subdivision (b) of this section to file the required information.

[(iii)] (3) Adjustments to certified rates made pursuant to section 86-2.11 of this Subpart shall be certified by the Commissioner of Health within 90 days from the date upon which a facility's rate was last certified pursuant to this Subpart or within 90 days from the latest scheduled PRI submission date pursuant to section 86-2.11 of this Subpart, whichever is later. Such ninety day time frames shall not apply in any instance where a facility has been notified that its submitted PRI data is inaccurate or incorrect pursuant to paragraph (e)(4) of [subdivision (e) of section 86-2.30 of] this [Subpart] section until such data has been corrected to the satisfaction of the commissioner, or if an additional on-site review has been deemed necessary pursuant to paragraph (e)(5) of [subdivision (e) of section 86-2.30 of] this [Subpart] section.

TN **91 - 4** Approval Date **JUL 2 - 1993**
Supersedes TN **87-7** Effective Date **JAN 1 - 1991**

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upon approval of
NY 87-7

2.31 Recalibration. (a) For rate periods commencing on or after January 1, 1987, notwithstanding any other provisions of this Subpart, the Direct Component of facility rates, determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart, shall be reduced by 3.035 percent to reflect a recalibration adjustment based on the change in the aggregate statewide case mix index attributable to factors other than changes in patient population or condition.

(b) The reduction in the Direct Component of facility rates as defined in subdivision (a) of this section shall be implemented on or about July 1, 1987 and shall be applied retroactive to January 1, 1987.

NY 87-6 Supersedes

Approval Date JAN 18 1989

Effective Date JAN 1 1987

(b) For rate years 1992 and thereafter, notwithstanding any other provision of this Subpart and subject to the provisions of paragraph (1) of this subdivision and subdivision (c) of this section, payment rates shall be adjusted in accordance with this subdivision to reflect a percentage recalibration adjustment based on the change in each facility's case mix which has been determined by the department to be due to factors other than changes in patient population or condition. Such payment rate adjustments shall be implemented utilizing the direct component of facility rates for such rate years determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(1) The percentage recalibration adjustment provided for in this subdivision shall not be less than 0% nor greater than one hundred fifty percent of the statewide weighted average percentage recalibration adjustment obtained by utilizing the facility-specific percentage recalibration adjustments as determined pursuant to this subdivision.

(2) The percentage recalibration adjustment shall be calculated as follows for each facility:

(i) A statewide distribution of patients in each patient classification group shall be determined by utilizing the patient data for the assessment of all patients obtained in the patient assessment period March 1, 1985 through September 30, 1985 (the 1985 period) conducted pursuant to section 86-2.30 of this Subpart.

(ii) The statewide distribution of patients in each patient classification group shall be further segregated by the following length of stay (LOS) groups:

- (a) less than or equal to 90 days
- (b) greater than 90 days but less than or equal to 1 year
- (c) greater than 1 year but less than or equal to 2 years
- (d) greater than 2 years but less than or equal to 3 years

TN 92-07 Approval Date AUG 21 1986
Supersedes TN New Effective Date JAN 01 1992

- (e) greater than 3 years but less than or equal to 4 years
- (f) greater than 4 years but less than or equal to 5 years
- (g) greater than 5 years

(iii) A statewide average initial case mix index for each LOS group for the 1985 period shall be calculated by multiplying the initial distribution of patients in each patient classification group within each LOS group times the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the total number of patients in all patient classification groups within each LOS group.

(iv) For each facility, a 1985 distribution of patients in each patient classification group and a 1985 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data for the assessment of all patients obtained in the 1985 period, conducted pursuant to section 86-2.30 of this Subpart. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility has the lesser of ten cases or twenty percent of its patients in the distributions as determined in this subparagraph for the 1985 period, or if the facility had undergone the appointment of a receiver or the establishment of a new operator

TN 92-07 Approval Date AUG 21 1996
Supersedes TN **New** Effective Date JAN 01 1992

subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the distribution of patients to be used for the purposes of this subparagraph shall be that distribution pertaining to the earliest full patient assessment period conducted pursuant to section 86-2.30 of this Subpart subsequent to the 1985 period or subsequent to the effective date of the appointment of a receiver or the change in operator (the "substituted 1985 period"), and such distribution shall be deemed the facility's "substituted 1985 distribution" of patients for the calculations in subparagraphs (vi) and (vii) of this paragraph. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that have been identified by the department as also having been included in the patient assessment period July 1, 1988 through December 31, 1988.

(v) For each facility, a 1988 distribution of patients in each patient classification group and a 1988 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data obtained in the patient assessment period July 1, 1988 through December 31, 1988. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that were admitted to the facility in which they are presently residing before October 1, 1985 and have been identified by the department as also having been included in the patient assessments during the 1985 period. In the event a facility commenced operations after the

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Supersedes TN New Effective Date JAN 01 1992

patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988 or if the facility had the lesser of ten cases or twenty percent of its patients in the distributions for the 1985 period as determined pursuant to subparagraph (iv) of this paragraph, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the facility's substituted 1985 period, as defined in subparagraph (iv) of this paragraph, shall be used in lieu of the 1985 period for the purposes of this subparagraph, and the only patients to be included shall be patients that were admitted to the facility in which they are presently residing before the end date of the facility's substituted 1985 period and have been identified by the department as also having been included in the patient assessments during the substituted 1985 period.

(vi) A percentage increase in case mix attributable to LOS shall, for each facility, be determined as follows:

(a) A 1985 aggregate case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, within each LOS group, determined pursuant to subparagraph (iv) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (iv) of this paragraph.

TN 92-07 Approval Date AUG 21 1996
Supersedes TN **New** Effective Date JAN 01 1992